

2010 Section SR7B Conclave Delegate Registration Form Tsoiotsi Tsogalii Lodge



April 16-18, 2010
Camp Boddie – Croatan Lodge #117
Blounts Creek, NC

Delegate Information:

Name: _____

Address: _____

City State & Zip: _____

Telephone: _____

Email: _____

Date of Birth: _____

Chapter: _____

Ordeal / Brotherhood / Vigil: _____

Dietary Needs: _____

Emergency Contact:

Name: _____

Relationship: _____

Day Telephone: _____

Evening Telephone: _____

Registration Deadline:

Early Bird Registration*

March 15, 2010

*Qualifies for Early Bird Patch

Return To:

Old North State Council

P. O. Box 29046

Greensboro, NC 27429

Delegate Fee:

\$40

Make Check Payable to:

Old North State Council

Fee Includes:

Conclave Fees

All Meals

Lodge Spirit Items

Indicate Shirt Size

(circle one)

S M L XL 2XL 3XL

Medical Form:

Mail with registration or bring

with you to Conclave

Must Have a Medical Form to

Participate

I Need Transportation

Yes No (circle one)

I Can Provide Transportation

for ___ riders

Photo release statement

I hereby give the Section permission to use any photos in which I appear that are taken at Conclave for use in promoting future events.

Signature: _____

Date: _____

2010 Section SR7B Conclave

Tsoitsi Tsogalii Lodge 70 - Delegate Medical Form

To be filled out by parent/guardian or adult participant. Please print in ink.		
Delegate Information		
Name:	Email:	
Address:		
City	State:	Zip Code:
Phone: ()	Date of Birth:	
Circle One:	Ordeal	Brotherhood
		Vigil
Primary Emergency Contact		
Name:	Relationship:	
Day Phone: ()	Evening Phone: ()	
Secondary Emergency Contact		
Name:	Relationship:	
Day Phone: ()	Evening Phone: ()	
Medical Information		
Do you: <input type="checkbox"/> have any medical restrictions? <input type="checkbox"/> currently take any medications? <input type="checkbox"/> have any dietary restrictions?	Explain:	
Health Insurance Company:	Policy #:	
Have or subject to: <input type="checkbox"/> Convulsions <input type="checkbox"/> Asthma <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Allergy to medication, food, plant, animal, insect <input type="checkbox"/> A condition requires special care, medication, diet <input type="checkbox"/> NONE OF THE ABOVE APPLY <input type="checkbox"/> Other	Explain:	
<input type="checkbox"/> Any condition now requiring regular medication?	Name of medication:	
Last Tetanus toxiod date:		
I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as the judgment of medical personnel dictates.		
In case of emergency , I understand every effort will be made to contact me (an adult, my spouse or next of kin). In the event, I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including but not limited to hospitalization, anesthesia, surgery, or injections of medications for my child (or for me, if an adult)		
Participant		Parent or Guardian
Signature:	Signature (if participant under 18 years):	
Date: _____	Date: _____	